

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9139

## CERTIFICATE OF DEATH

Reg. Dist. No.

09110

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kitzmillers</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Week Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OKEY</u> Middle <u>H</u> Last <u>Ball</u>		4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 7 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wheelman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>	
11. BIRTHPLACE (State or foreign country) <u>W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Ball</u>		14. MOTHER'S MAIDEN NAME <u>Mary E Ailer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Weeks Nursing Home</u>		Address <u>Oakland Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, Generalized</u> DUE TO (c) <u>Coronary Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SLEUTH</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>Aug 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8.20</u> , 19 <u>59</u> , and that death occurred at <u>7.15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Oakland Md</u> DATE SIGNED <u>8.23.59</u> ACTUAL SIGNATURE <u>James H. Fenster</u> M.D. PHYSICIAN'S NAME (Type) <u>JAMES H. FENSTER Sr. 40 58 2-1 st.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>August 25-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hamill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Kitzmillers MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Kyle Priths Jr.</u>		ADDRESS <u>Kitzmillers, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>AUG 25 59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Pines</u>	



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09111

## 9140 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>9 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett Co. Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>E.</b> Last <b>Barrick</b>		4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2-27-1901</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>	
11. BIRTHPLACE (State or foreign country) <b>Kitzmiller, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Henry Barrick</b>		14. MOTHER'S MAIDEN NAME <b>Martha Mason</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-01-6574</b>	
17. INFORMANT <b>"Mother" Martha M. Barrick, Kitzmiller, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>15 hemmatic heart disease</b> DUE TO <b>416X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial heart disease with</b> DUE TO <b>Chronic failure</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-27</b> , 19 <b>59</b> , to <b>8-30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8-30-59</b> , 19 <b>59</b> , and that death occurred at <b>10:05A</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.		ADDRESS (Street, city or town, state) <b>Oakland, Md</b> DATE SIGNED <b>3 Aug 59</b>	
PHYSICIAN'S NAME (Type) <b>Andrew E. Mance, M. D.</b>		<b>Oakland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9-2-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Kaulbaugh</b>		22d. LOCATION (City, town, or county) (State) <b>ELK GARDEN WVA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert Kyle Priddy, Jr. Kitzmiller, Md</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9141

## CERTIFICATE OF DEATH

Reg. Dist. No.

09112

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park</b>		c. LENGTH OF STAY IN 1b <b>6 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Jane</b> Last <b>Bittinger</b>		4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1882</b>
9. AGE (In years last birthday) yrs. <b>77</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Miller</b>		14. MOTHER'S MAIDEN NAME <b>Malissa DeWitt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>Clinton Bittinger</b>		Address <b>Mt. Lake Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Myocardial infarction, Route 12 hours</b> DUE TO (b) <b>Arteriosclerotic Cardio Vascular disease</b> DUE TO (c) <b>unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 15, 1959</b> to <b>Aug 31, 1959</b> , that I last saw the deceased alive on <b>Aug 15, 1959</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak Street, Oakland, Md.</b> DATE SIGNED <b>Sept 8</b>	
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.</b> <b>Oakland, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/3/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cemetery near Oakland, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of school		18. Signature of hospital		19. Signature of nursing home		20. Signature of other institution	
21. Signature of other institution		22. Signature of other institution		23. Signature of other institution		24. Signature of other institution	
25. Signature of other institution		26. Signature of other institution		27. Signature of other institution		28. Signature of other institution	
29. Signature of other institution		30. Signature of other institution		31. Signature of other institution		32. Signature of other institution	
33. Signature of other institution		34. Signature of other institution		35. Signature of other institution		36. Signature of other institution	
37. Signature of other institution		38. Signature of other institution		39. Signature of other institution		40. Signature of other institution	
41. Signature of other institution		42. Signature of other institution		43. Signature of other institution		44. Signature of other institution	
45. Signature of other institution		46. Signature of other institution		47. Signature of other institution		48. Signature of other institution	
49. Signature of other institution		50. Signature of other institution		51. Signature of other institution		52. Signature of other institution	
53. Signature of other institution		54. Signature of other institution		55. Signature of other institution		56. Signature of other institution	
57. Signature of other institution		58. Signature of other institution		59. Signature of other institution		60. Signature of other institution	
61. Signature of other institution		62. Signature of other institution		63. Signature of other institution		64. Signature of other institution	
65. Signature of other institution		66. Signature of other institution		67. Signature of other institution		68. Signature of other institution	
69. Signature of other institution		70. Signature of other institution		71. Signature of other institution		72. Signature of other institution	
73. Signature of other institution		74. Signature of other institution		75. Signature of other institution		76. Signature of other institution	
77. Signature of other institution		78. Signature of other institution		79. Signature of other institution		80. Signature of other institution	
81. Signature of other institution		82. Signature of other institution		83. Signature of other institution		84. Signature of other institution	
85. Signature of other institution		86. Signature of other institution		87. Signature of other institution		88. Signature of other institution	
89. Signature of other institution		90. Signature of other institution		91. Signature of other institution		92. Signature of other institution	
93. Signature of other institution		94. Signature of other institution		95. Signature of other institution		96. Signature of other institution	
97. Signature of other institution		98. Signature of other institution		99. Signature of other institution		100. Signature of other institution	



STATE DEPARTMENT OF HEALTH - BATHING 18

## 09113

**MEDICAL CERTIFICATION**

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

DECEASED NAME JAMES M. SMITH		SEX Male		AGE 30 years	
PLACE OF BIRTH BALTIMORE, MD.		OCCUPATION Clerk		CAUSE OF DEATH Heart Disease	
DATE OF DEATH Jan 15, 1918		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES J. M. Smith, Jr. J. M. Smith, Sr.		SIGNATURE OF PHYSICIAN J. M. Smith, M.D.	
SIGNATURE OF CLERK J. M. Smith		SIGNATURE OF REGISTRAR J. M. Smith		SIGNATURE OF JURY J. M. Smith, Foreman J. M. Smith, Member J. M. Smith, Member	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

9143

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09114

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville</u>	c. LENGTH OF STAY IN 1b <u>1 yr</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>		d. STREET ADDRESS <u>R.F.D.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Bliss - Fred - Friend</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-19-1905</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rooming house</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John H. Friend</u>	
14. MOTHER'S MAIDEN NAME <u>Eliza J. Dunkel</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>720-1038</u>		17. INFORMANT <u>Arthur Humberg - Friendsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7740 CARDIAC INSTABILITY</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) gave rise to the underlying cause last. (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>77 MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>J. H. FEASTER, JR. MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-2-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 5-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Blooming Rose Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Friendsville - RD. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Rodakover</u>		ADDRESS <u>Marketburg Pa</u>	
24a. REC'D BY REGISTRAR <u>AUG 6 59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Friend</u>	

SS. NO 220-10-2869 X

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2148

1. DECEASED'S NAME (Last, first, middle initial) <i>JOHN EDWARD SMITH</i>		2. DECEASED'S SEX <i>Male</i>	
3. DECEASED'S AGE (Years, months, days) <i>45 - 3 - 15</i>		4. DECEASED'S BIRTH DATE <i>Aug 15, 1900</i>	
5. DECEASED'S BIRTH PLACE <i>Baltimore, Md.</i>		6. DECEASED'S RACE <i>White</i>	
7. DECEASED'S OCCUPATION <i>Engineer</i>		8. DECEASED'S MARITAL STATUS <i>Married</i>	
9. DECEASED'S RELIGION <i>Catholic</i>		10. DECEASED'S EDUCATION <i>High School</i>	
11. DECEASED'S SOCIAL SECURITY NUMBER <i>34-123456789</i>		12. DECEASED'S HOME ADDRESS <i>1234 Main St, Baltimore, Md.</i>	
13. DECEASED'S PHONE NUMBER <i>555-1234</i>		14. DECEASED'S MOTHER'S MAIDEN NAME <i>JOHN EDWARD SMITH</i>	
15. DECEASED'S FATHER'S NAME <i>JOHN EDWARD SMITH</i>		16. DECEASED'S MOTHER'S NAME <i>JOHN EDWARD SMITH</i>	
17. DECEASED'S BIRTH CERTIFICATE NUMBER <i>123456789</i>		18. DECEASED'S DEATH CERTIFICATE NUMBER <i>123456789</i>	
19. DECEASED'S DEATH DATE <i>Aug 15, 1945</i>		20. DECEASED'S DEATH TIME <i>10:00 AM</i>	
21. DECEASED'S DEATH PLACE <i>Home</i>		22. DECEASED'S DEATH CAUSE <i>Heart Disease</i>	
23. DECEASED'S DEATH PLACE <i>Home</i>		24. DECEASED'S DEATH PLACE <i>Home</i>	
25. DECEASED'S DEATH PLACE <i>Home</i>		26. DECEASED'S DEATH PLACE <i>Home</i>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9144

Item 9 Film G248 9-9-59 et

## CERTIFICATE OF DEATH

09115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Swanton, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Swanton, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>BOWERS</u> Last <u>GREEN</u>		4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1871</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>New Germany, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Bowers</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Broadwater</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Everett Green, R.D. Swanton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Erysipelas</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Crowning Heart Disease &amp; Hypertension</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter notes of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>Aug 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 11</u> , 19 <u>59</u> , and that death occurred at <u>  </u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>Aug 17-59</u>			
ACTUAL SIGNATURE <u>Ralph Calandrella</u> M.D.		DATE SIGNED <u>Aug 17-59</u>	
PHYSICIAN'S NAME (Type) <u>RALPH CALANDRELLA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Germany Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Rural Grantsville, Garrett</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u>		ADDRESS <u>Grantsville, Md/</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
DATE <u>AUG 21 '59</u>			

CLAIM BOOK

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Death in presence of witnesses  
Eugene J. [illegible]

Coroner's Office + Affirmation

KATHA CARANDREWA  
Left Colon. [illegible]  
Jan 27 1913

27 Jan 13

17-18 Jan 13

26 Jan 13

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9145

## CERTIFICATE OF DEATH

09116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland Md.</b>		c. LENGTH OF STAY IN 1b <b>3-6 mo</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Evans Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George H. Harding</b>		4. DATE OF DEATH <b>AUG - 28 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2-1867</b>
9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	11. BIRTHPLACE (State or foreign country) <b>Indiana</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Not Known</b>	
14. MOTHER'S MAIDEN NAME <b>Not Known</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Slide Hilt, Ellerslie Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b>Sen. L.T.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>4 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-28 1957</b> to <b>8-28 1959</b> , that I last saw the deceased alive on <b>8-28 1959</b> , and that death occurred at <b>3:40 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>		ADDRESS (Street, city or town, state) <b>5821 St. Oakland - 1</b>	
PHYSICIAN'S NAME (Type) <b>James H. Feaster, Jr.</b>		DATE SIGNED <b>8-28-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUG 31 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Steele Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Friendsville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Rodakaven - Markleysburg Pa</b>		ADDRESS <b>Markleysburg Pa</b>	
24a. REC'D BY REGISTRAR <b>AUG 31 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

9152

18-10-18

NAME OF DECEASED: [illegible]  
 SEX: [illegible] AGE: [illegible]  
 DATE OF BIRTH: [illegible]  
 PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]  
 PLACE OF DEATH: [illegible]  
 CAUSE OF DEATH: [illegible]

DIAGNOSIS: [illegible]  
 MEDICAL ATTENDANT: [illegible]  
 SIGNATURE: [illegible]

DATE OF INTERMENT: [illegible]  
 PLACE OF INTERMENT: [illegible]  
 NAME OF FUNERAL HOME: [illegible]

DATE OF REPORT: [illegible]  
 NAME OF REPORTER: [illegible]  
 SIGNATURE: [illegible]

DATE OF REVIEW: [illegible]  
 NAME OF REVIEWER: [illegible]  
 SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible]  
 NAME OF FINAL REVIEWER: [illegible]  
 SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible]  
 NAME OF FINAL REVIEWER: [illegible]  
 SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible]  
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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9146 CERTIFICATE OF DEATH

Reg. Dist. No.

09118

1. PLACE OF DEATH o. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KITZMILLER</b>				c. LENGTH OF STAY IN 1b <b>3 1/2 YEARS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KITZMILLER</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>HIRAN</b> Last <b>JONES</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>17</b> Year <b>1959</b>									
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 9, 1884</b>		9. AGE (In years lost birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPT. OF MINES</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MINES</b>				11. BIRTHPLACE (State or foreign country) <b>OHIO</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>HAMBLETON B. JONES</b>				14. MOTHER'S MAIDEN NAME <b>ELLA CLEWELL</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>215-07-1981</b>	
17. INFORMANT <b>NANNIE SMITH JONES</b>				Address <b>KITZMILLER, MD.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary-Vascular Renal Disease</b> DUE TO <b>with edema</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>3 yrs.</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Jan 16, 1959</b> to <b>Aug 17, 1959</b> , that I last saw the deceased alive on <b>Aug 16, 1959</b> , and that death occurred at <b>8:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>KITZMILLER MD</b> DATE SIGNED <b>Aug 18, 59</b> ACTUAL SIGNATURE <b>Ralph Calandrella</b> M.D. PHYSICIAN'S NAME (Type) <b>RAHph CALANDRELLA</b>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>AUGUST 19, 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>IOOF</b>		22d. LOCATION (City, town, or county) (State) <b>ELK GARDEN WVA.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT KYLE PRITTS SR.</b>						ADDRESS <b>KITZMILLER MD.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9147

## CERTIFICATE OF DEATH

09119

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crellin</b>				c. LENGTH OF STAY IN 1b <b>1 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crellin</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Okey Babb Junkins</b>				4. DATE OF DEATH Month <b>8</b> Day <b>11</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 10, 1886</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stable work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Kitzmilller, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>Mary Virginia Junkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give year or dates of service) <b>10/27/36</b>				16. SOCIAL SECURITY NO. <b>232-10-8704</b>		17. INFORMANT <b>Bertha E. Junkins</b> Address <b>Crellin, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>See below mellitus</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3/6/55</b> , 19____, to <b>8/11/59</b> , 19____, that I last saw the deceased alive on <b>2/13/59</b> , 19____, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>E. D. Baumgartner</b> M.D. <b>Oakland, Md.</b> DATE SIGNED <b>8/12/59</b> PHYSICIAN'S NAME (Type) <b>Dr. E. Irving Baumgartner</b> ADDRESS <b>25 Alder St. Oakland, Md.</b> <b>8/12/1959</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8/14/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Minnich Funeral Home</b>				ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>							





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

9148

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09117

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY <b>MINERAL</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(RURAL) OAKLAND</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEYSER</b> <b>85X-3</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NONE</b>			d. STREET ADDRESS <b>166 S. MAIN ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>ANN</b> Last <b>KITZMILLER</b>			4. DATE OF DEATH Month <b>AUG</b> Day <b>23</b> Year <b>19 59</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 1ST., 1933</b>		9. AGE (In years last birthday) <b>26</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OFFICE WORK</b>	11. BIRTHPLACE (State or foreign country) <b>KEYSER, WEST VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>THOMAS KITZMILLER</b>			14. MOTHER'S MAIDEN NAME <b>BESSIE BURNS</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>236-48-3178</b>	17. INFORMANT <b>BESSIE BURNS KITZMILLER, KEYSER, W. VA.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>936.8</b> IMMEDIATE CAUSE (a) <b>EVISCERATION OF ABDOMINAL CONTENTS SECONDARY TO MULTIPLE LACERATIONS OF RIGHT HIP, ABDOMEN AND BACK</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>STRUCK BY MOTOR BOAT AT DEEP CREEK LAKE, MD.</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>5</b> P. M. <b>8-23</b> 19 <b>59</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>LAKE</b>	20f. (City or town) <b>(RURAL) OAKLAND</b>	(County) <b>GARRETT</b>	(State) <b>MD.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>JAMES H. FEASTER, JR., M. D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-26-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>QUEENS POINT</b>		22d. LOCATION (City, town, or county) (State) <b>KEYSER W. VA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>MINNICH FUNERAL HOME, OAKLAND, MD.</b>			24a. REC'D BY REGISTRAR DATE <b>AUG 26 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>

8-24-59

DATE SIGNED



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9149

## CERTIFICATE OF DEATH

09120

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		STATE <u>Md.</u> COUNTY <u>GARRETT</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>FRIENDSVILLE</u>		LENGTH OF STAY (in this place) <u>18 yrs</u>		TOWN <u>FRIENDSVILLE</u>		TOWN <u>FRIENDSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>No number</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>SILAS - FRANCIS - SAVAGE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Aug - 31 - 19 59</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 10 - 1880</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JERRY Savage</u>				14. MOTHER'S MAIDEN NAME <u>Mary Whitstone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>172-16-5103</u>		17. INFORMANT & ADDRESS <u>John Savage - Friendsville Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
191.3 IMMEDIATE CAUSE (A) <u>CARDIORESPIRATORY FAILURE</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO <u>Extreme Cachexia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>CARCINOMA of the FACE</u>				6 mo.			
STATING UNDERLYING CAUSE LAST. (C) <u>None</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 3, 19 57</u> , to <u>Aug 31, 19 57</u> , that I last saw the deceased alive on <u>Aug 25, 19 59</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Pedro Rivera</u> M.D. <u>Box L-7 Friendsville, Md</u>				DATE SIGNED <u>1959</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 3 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Addison Cemetery</u>		LOCATION (City, town, or county) (State) <u>Addison Pa</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur E. Knapp</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Rodakauer</u>		ADDRESS <u>Marketburg Pa</u>	
DATE <u>SEP 3 '59</u>							

# CERTIFICATE OF DEATH

1912

For Use by

1. DEATH RECORDING OFFICE OF BALTIMORE

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. OCCUPATION

7. DATE OF BIRTH

8. PLACE OF BIRTH

9. MARITAL STATUS

10. COLOR

11. RELIGION

12. EDUCATION

13. PREVIOUS ILLNESS

14. CAUSE OF DEATH

15. MANNER OF DEATH

16. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF WITNESSES

18. SIGNATURE OF REGISTRAR

19. DATE OF DEATH

20. TIME OF DEATH

21. PLACE OF INTERMENT

22. NAME OF INTERMENT PLACE

23. GRAVE NUMBER

24. NAME OF CLERGYMAN

25. NAME OF FUNERAL HOME

26. NAME OF CARRIER

27. NAME OF BURIAL SOCIETY

28. NAME OF SINGERS

29. NAME OF MUSICIANS

30. NAME OF OTHER PARTICIPANTS

31. NAME OF OFFICIATING CLERGYMAN

32. NAME OF ASSISTING CLERGYMAN

33. NAME OF DEACONS

34. NAME OF ALTERNATE DEACONS

35. NAME OF LITURGISTS

36. NAME OF OTHER PARTICIPANTS

37. NAME OF OFFICIATING CLERGYMAN

38. NAME OF ASSISTING CLERGYMAN

39. NAME OF DEACONS

40. NAME OF ALTERNATE DEACONS

41. NAME OF LITURGISTS

42. NAME OF OTHER PARTICIPANTS

43. NAME OF OFFICIATING CLERGYMAN

44. NAME OF ASSISTING CLERGYMAN

45. NAME OF DEACONS

46. NAME OF ALTERNATE DEACONS

47. NAME OF LITURGISTS

48. NAME OF OTHER PARTICIPANTS

49. NAME OF OFFICIATING CLERGYMAN

50. NAME OF ASSISTING CLERGYMAN

51. NAME OF DEACONS

52. NAME OF ALTERNATE DEACONS

53. NAME OF LITURGISTS

54. NAME OF OTHER PARTICIPANTS

55. NAME OF OFFICIATING CLERGYMAN

56. NAME OF ASSISTING CLERGYMAN

57. NAME OF DEACONS

58. NAME OF ALTERNATE DEACONS

59. NAME OF LITURGISTS

60. NAME OF OTHER PARTICIPANTS

61. NAME OF OFFICIATING CLERGYMAN

62. NAME OF ASSISTING CLERGYMAN

63. NAME OF DEACONS

64. NAME OF ALTERNATE DEACONS

65. NAME OF LITURGISTS

66. NAME OF OTHER PARTICIPANTS

67. NAME OF OFFICIATING CLERGYMAN

68. NAME OF ASSISTING CLERGYMAN

69. NAME OF DEACONS

70. NAME OF ALTERNATE DEACONS

71. NAME OF LITURGISTS

72. NAME OF OTHER PARTICIPANTS

73. NAME OF OFFICIATING CLERGYMAN

74. NAME OF ASSISTING CLERGYMAN

75. NAME OF DEACONS

76. NAME OF ALTERNATE DEACONS

77. NAME OF LITURGISTS

78. NAME OF OTHER PARTICIPANTS

79. NAME OF OFFICIATING CLERGYMAN

80. NAME OF ASSISTING CLERGYMAN

81. NAME OF DEACONS

82. NAME OF ALTERNATE DEACONS

83. NAME OF LITURGISTS

84. NAME OF OTHER PARTICIPANTS

85. NAME OF OFFICIATING CLERGYMAN

86. NAME OF ASSISTING CLERGYMAN

87. NAME OF DEACONS

88. NAME OF ALTERNATE DEACONS

89. NAME OF LITURGISTS

90. NAME OF OTHER PARTICIPANTS

91. NAME OF OFFICIATING CLERGYMAN

92. NAME OF ASSISTING CLERGYMAN

93. NAME OF DEACONS

94. NAME OF ALTERNATE DEACONS

95. NAME OF LITURGISTS

96. NAME OF OTHER PARTICIPANTS

97. NAME OF OFFICIATING CLERGYMAN

98. NAME OF ASSISTING CLERGYMAN

99. NAME OF DEACONS

100. NAME OF ALTERNATE DEACONS

101. NAME OF LITURGISTS

102. NAME OF OTHER PARTICIPANTS

103. NAME OF OFFICIATING CLERGYMAN

104. NAME OF ASSISTING CLERGYMAN

105. NAME OF DEACONS

106. NAME OF ALTERNATE DEACONS

107. NAME OF LITURGISTS

108. NAME OF OTHER PARTICIPANTS

109. NAME OF OFFICIATING CLERGYMAN

110. NAME OF ASSISTING CLERGYMAN

111. NAME OF DEACONS

112. NAME OF ALTERNATE DEACONS

113. NAME OF LITURGISTS

114. NAME OF OTHER PARTICIPANTS

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9150

CERTIFICATE OF DEATH

Reg. Dist. No.

09121

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>8 mos.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> <b>01-22-2</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Weeks Nursing Home</b>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Elizabeth</b> <b>Sliger</b>		4. DATE OF DEATH <b>August</b> <b>5</b> <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/28/1879</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>cafeteria</b>	11. BIRTHPLACE (State or foreign country) <b>Lonacoring, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert Matheny</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Russell</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>215-16-4377A</b>		17. INFORMANT <b>Robert Sliger</b> <b>Wheeling, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>444X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old Intertrochanteric Fracture Left Femur.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 20, 1959</b> , to <b>Aug 5, 1959</b> , that I last saw the deceased alive on <b>August 2, 1959</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>35 ARDER ST OAKLAND</b> DATE SIGNED <b>8/6/59</b>			
ACTUAL SIGNATURE <b>E. I. BAUMGARTNER</b> M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	
22b. DATE THEREOF <b>8/8/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Oakland Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Minnich Funeral Home Oakland Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Klaus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



